

**PATIENT REGISTRATION FORM**

Patient's Name: \_\_\_\_\_  
(Last) (First) (M.I.) (Mr., Mrs., Ms., Dr.)

Check one: \_\_\_\_\_ child \_\_\_\_\_ single \_\_\_\_\_ married \_\_\_\_\_ widowed \_\_\_\_\_ divorced  
Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

**(To respect your privacy, please ONLY list the phone number(s) where we may call you.)**

Home Phone: _____	May we leave a message on voice mail? _____ Yes _____ No
Work Phone: _____	May we leave a message on voice mail? _____ Yes _____ No
Cell Phone: _____	May we leave a message on voice mail? _____ Yes _____ No

E-Mail: \_\_\_\_\_ Student? \_\_\_\_\_ Yes \_\_\_\_\_ No P/T F/T  
Employed By: \_\_\_\_\_ Occupation: \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ Employer: \_\_\_\_\_  
Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_\_

Previous Dentist: \_\_\_\_\_ Address: \_\_\_\_\_  
Approximate Date of Last Thorough Dental Exam: \_\_\_\_\_

How did you hear about us?  
\_\_\_\_\_ Referred by: \_\_\_\_\_ Website \_\_\_\_\_ Location \_\_\_\_\_ Phone Book  
\_\_\_\_\_ Other: \_\_\_\_\_ Newspaper

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**~PRIMARY INSURANCE~**

Insurance Company: _____	Employer: _____
Insurance Phone #: _____	Group #: _____
Address to Submit Claims: _____	
Policyholders' Name: _____	Relationship to Patient: _____
Policyholders' Address: _____	
Policyholders' SS# or ID#: _____	Date of Birth: ____/____/____

**~SECONDARY INSURANCE~**

Insurance Company: _____	Employer: _____
Insurance Phone #: _____	Group #: _____
Address to Submit Claims: _____	
Policyholders' Name: _____	Relationship to Patient: _____
Policyholders' Address: _____	
Policyholders' SS# or ID#: _____	Date of Birth: ____/____/____

I understand that my dental insurance is a contract between the insurance carrier and me, and **not** between the insurance carrier and True North Dentistry. **I understand that I am fully responsible, regardless of benefits, for all dental fees at the time of service unless prior arrangements have been made with the office.** Any balance due past the end of the month may be subject to a finance charge computed at 2% per month. I agree to pay all costs and expenses incurred should this account be turned over to an attorney, collection agency, including attorney fees, collection agency fees & court costs. Our office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. If there is an open balance, a statement will be sent to you.

Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_  
Date: \_\_\_\_\_ (Parent or Guardian Signature is required if patient is a minor: under 18 years of age)